



ONGOING MEDICATION FORM



Child Name **Child class**

Parent/carer name **Contact number**

I request that designated staff members at Hollywell Primary School assist in the administration of the following medicine on an ongoing basis.

Medical Condition/Diagnosis.....

Medicine

Dosage.....

Time for medication to be administered.....

Doctor name **Telephone number**.....

Practice address

.....
.....

Please attach a letter (on a professional letter head) from your child’s doctor outlining the following –

- * CHILD’S FULL NAME
- * CHILD’S MEDICAL CONDITION OR DIAGNOSIS
- * MEDICATION/S TO BE ADMINISTERED
- * AMOUNT / DOSE TO BE ADMINISTERED
- * TIME THAT THE MEDICATION IS TO BE ADMINISTERED
- * A CHILD WITH ALLERGIES THAT NEEDS AN EPIPEN MUST HAVE AN ANYPHYLAXIS PLAN FILLED IN BY THEIR DOCTOR ***

*Please note that we need the actual box that contains the medication. The box must have your child’s name on it. Without the name we will **NOT** administer the medication (asthma puffers excluded)*

Please print and sign this form and hand it back to a designated staff member.

Date Signed.....(parent/carer)

Date Signed.....(staff member)